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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION ONE

THE PEOPLE, Plaintiff and Respondent, v. JEFFREY G., Defendant and Appellant.	A154893 (Napa County Super. Ct. No. CR127321)

Following a jury trial, defendant's commitment to the State Department of State Hospitals was extended two more years pursuant to Penal Code section 1026.5, subdivision (b). Defendant contends there is insufficient evidence to support the jury's finding he has serious difficulty controlling his dangerous behavior. We disagree and affirm.

I. PROCEDUAL AND FACUTAL BACKGROUND

After defendant was convicted of assault with a deadly weapon in 1982 (Pen. Code,[1] § 245, subd. (a)(1)), he was involuntarily committed to Napa State Hospital. While housed at the hospital, he committed a subsequent assault with a deadly weapon in 2005. He was convicted of assault with a deadly weapon (§ 245, subd. (a)(1)) in 2006, and he has been involuntarily committed to Napa State Hospital since May 2006 to the present.[2] In *People v Jeffrey G.* (2017) 13 Cal.App.5th 501, we reversed the trial court's

[1] All further statutory references are to the Penal Code.

[2] The parties stipulated defendant was "convicted" of the 1982 and 2005 assaults and was "involuntarily committed." We have not found any reference in the

denial of defendant's petition for conditional release, holding the prosecution's expert testimony was erroneously admitted at trial in violation of *People v. Sanchez* (2016) 63 Cal.4th 655 (limiting expert testimony with respect to case-specific hearsay evidence).

In January 2018, the Napa County District Attorney filed a petition to extend defendant's commitment at the state hospital pursuant to section 1026.5, subdivision (b), alleging defendant "by reason of mental disease, defect, or disorder represents a substantial danger of physical harm to others." In July 2018, a jury found defendant suffers from a mental disorder and because of his mental disorder poses a substantial danger of physical harm to others and has serious difficulty in controlling his dangerous behavior. The court thereafter signed an order committing defendant to Napa State Hospital from June 6, 2018 until June 6, 2020.

A. Prosecution's Case

At trial the prosecution called seven witnesses—two psychiatrists, two psychologists, two nurses, and a social worker—all of whom had contact with or treated defendant at Napa State Hospital.

Dr. Amrid Saini

Dr. Saini, a staff psychiatrist at Napa State Hospital, testified he worked with patients with serious mental disorders who are housed in a locked unit. Dr. Saini treated defendant from November 2016 to February 2017 and spoke with him "many times," "[a]lmost daily." In Saini's opinion, defendant suffers from schizoaffective disorder bipolar type. Schizoaffective disorder, according to the doctor, is a major mental disorder, manifesting symptoms of a psychotic nature, and symptoms of schizophrenia which can include auditory hallucination, disorganized process or speech, the loss of the ability to do normal things, and mood disorder such as major depression or mania. When Dr. Saini treated defendant, he observed some of these symptoms. Defendant was having behavioral problems, becoming easily angered and irritated. He was also moody,

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testimony or in the jury instructions that the jury was informed defendant had been found not guilty by reason of insanity.

paranoid, and suspicious of his peers and treatment team. Although defendant's symptoms were well controlled at the time he came under Dr. Saini's care, and he was making progress, the doctor observed a progressive worsening of the psychiatric symptoms which were increasing in number and "manifesting more intensely." These symptoms, in turn, were affecting defendant's behavior, causing him to have difficulties working with staff, interacting with peers, and carrying out his treatment plan. By the end of 2016, he was having major problems with his treatment team, disagreeing with them on his treatment. In February 2017, defendant developed significant symptoms, almost totally decompensating, and "his symptoms had worsened to the point where he was not able to effectively interact with his treatment team and carry on his treatment plan."

Defendant was on antipsychotic medication, receiving either two or three doses every day. In addition, he took medication to treat his bipolar disorder. These medications should be taken on a continuous basis to control the symptoms, and defendant, according to Dr. Saini, should be on antipsychotic medication for the rest of his life. Should defendant stop taking his antipsychotic medication, the doctor believed he would have a "high possibility of relapse" because schizoaffective disorder cannot be cured but can be controlled through medication.

In the latter part of 2016, defendant asked to have his medications decreased because he was feeling sedated during the daytime, had tremors in his hands, and was forgetful. Per defendant's request, Dr. Saini decreased his medications between June 2016 and January 2017. Defendant's behavior, however, became "more overtly aggressive," he became increasingly moody and irritable, his anxiety "started rising," and he became "very reactive." Because he was having difficulty controlling his anger, he began running into conflict with staff and peers. By January 2017, he had "clinically decompensated to the point where his treatment became very difficult." Though Dr. Saini kept explaining to defendant his symptoms were worsening, he was in denial. Defendant's treatment team also met with him multiple times to discuss his behavior but he had "difficulty in accepting the response by the team." He would deny the points

being made by the team, argue, or "provide his own understanding which was out of context." As a result, the team had "a lot of difficulty" collaborating with defendant and giving him insight into his disorder.

Whenever Dr. Saini met with defendant to discuss his medications, defendant would often ask to decrease them. In February 2017, defendant indicated his medication should be administered "at a certain dose." When Dr. Saini asked defendant how he makes his medication dosage decisions, defendant told the doctor that "he [(defendant)] knows pretty well how to make that decision and he makes that decision just like other people do." If released from Napa State Hospital, defendant told Dr. Saini he would probably take one of the medications, however, he would not like to take the antipsychotic medication because it was causing him side effects, and he did not believe he needed it. In fact, defendant believed he was making progress and had "developed enough skills to handle his symptoms on his own and so there would be no need to continue" with his medications. While Dr. Saini did not "definitely recall" defendant stating whether he would or would not take his medication if he were released into the community, the doctor testified since defendant was not "agreeable" to taking his medication, he assumed defendant would not continue to take his medication outside of the hospital. After Dr. Saini left his "unit," he reviewed reports of defendant's treating psychiatrists and noted defendant's pattern of requesting a decrease in his medication had continued. That pattern led Dr. Saini to conclude once defendant is released into the community where his supervision "would be much less than what he is getting at Napa State Hospital he would have the opportunity of stopping those medications, [specifically the antipsychotic medication,] not having good enough insight to continue them."

Dr. Saini considered approximately "20, 25 incidences," many of which occurred during the period June 2016 to January 2017, when defendant was acting out by becoming angry, argumentative, demanding, and threatening, once his medications had been decreased. We will not discuss all the incidents considered by the doctor and reflected in the record. Instead, we will focus on two incidents occurring on January 18, 2017 and one on January 20, 2017 as examples of defendant's decompensating behavior

during the time span his medications had been decreased. The first incident occurred on January 18 at 4:10 a.m., when staff directed defendant to cover his face since it was flu season. This request was made to patients who had active coughs. Defendant became very angry with staff, stating, "I will wake up the whole unit. I have been in the system for 40 years, don't play games with me, young lady, I don't need that shit." Later at 7:30 a.m., as patients were being given their medications, defendant became argumentative and angry with staff and very demanding. He told staff, "[Y]ou don't know what you are doing, I do not want you to take my vitals, or give me medications, you are black, you know nothing." On January 20, as defendant was "redirected" by a staff member, he made a threatening comment: "[D]on't talk to me, old woman. Your state job is the last place for you to work. I'm gonna tell your supervisor that you yelled at me."

Dr. Saini reported that on November 4, 2016, defendant asked for PRN's (requests for additional medications as needed) because he was feeling "very anxious and agitated" and because he needed extra medication to help him sleep. This request was significant to the doctor since a few days later, on November 10, per defendant's request, his dose for his antipsychotic medication, olanzapine, was decreased from 35 milligrams per day to 15 milligrams per day. Once defendant's dose of olanzapine was decreased, Dr. Saini observed defendant was "having an increase in the frequency and intensity of symptoms of anxiety, agitation, irritability." Asking for PRN's signified to the doctor that defendant was not being stabilized under his then-current prescribed dose of medication, and his need for that medication was probably higher than the dose he was taking.

In reaching his opinion that defendant poses a substantial danger of physical harm to others and has serious difficulty controlling his behavior, in addition to the incidents Dr. Saini documented, he considered defendant's convictions for assault with a deadly weapon in Napa County in 2006 and assault with a deadly weapon in Fresno in the 1980's, and "other instances in [defendant's] medical file" occurring before he entered the doctor's medical unit.

While defendant was housed in Dr. Saini's unit, he did not attack anyone other than "where he snatched a food item in front of a peer." The fact defendant was not physically aggressive or assaultive did not affect or change Dr. Saini's opinion as to whether defendant represents a substantial danger of physical harm to others because he was housed in one of the most highly structured and supervised units at Napa State Hospital where defendant "knows that he's always observed by the staff and if he tries to do any behavior of aggression that he'll be quickly intervened by staff who observes him [and] supervises him." Dr. Saini opined that being angry, verbally aggressive, making threatening statements to staff and peers, and not following his treatment plan can aggravate defendant's symptoms "to a level where physical aggression can happen."

Dr. Silvina Holasek

Dr. Silvina Holasek, the second psychiatrist to testify, had treated defendant for one and a half months. In the doctor's opinion, defendant suffers from a mental disorder, schizoaffective disorder bipolar type. He also has a narcissistic personality disorder and suffers from marijuana and alcohol use disorders. When defendant came to Dr. Holasek's unit, he was quite paranoid about his prior treatment team, prior staff, and a patient in his prior unit. While Dr. Holasek was treating defendant, he came down with pneumonia, and when he was taken to an outside hospital in Napa to have testing, he became afraid of a female technician, believing she wanted to kill him. Paranoia is a symptom of his schizoaffective disorder. If defendant does not take his antipsychotic medication for the rest of his life, Dr. Holasek believed he would decompensate and exhibit manic symptoms such as impulsiveness, inability to sleep, paranoia, and hallucinations.

Moreover, if defendant stops taking his antipsychotic medications, decompensates, and then begins taking them again, it would take four to six weeks for the medications to take effect before he went back to the way he was. Because it would take time for the medications to have their full effect, defendant would have psychotic decompensation and the more decompensation he experiences the harder it will be to make his symptoms go away.

Due to defendant's mental disorder, Dr. Holasek opined he poses a substantial danger of physical harm to others and has serious difficulty controlling his dangerous behavior. In reaching her conclusion, she considered her own personal observations, defendant's underlying offenses for assault with a deadly weapon in Napa and assault with a deadly weapon in Fresno, his medical file, and the opinions of defendant's prior psychologist, Dr. Marchbanks, and psychiatrists, Drs. Saini and Brar. If defendant were released from the hospital to an unsupervised environment, Dr. Holasek believed he would not continue to take his antipsychotic medication at the current dose on a regular basis because he does not think he needs to take the prescribed dose. Though she had explained to defendant multiple times he needs to stay on the prescribed dose, he continued to ask to have his medication reduced.

Dr. Karla Marchbanks-Onofre

Karla Marchbanks-Onofre (Dr. Marchbanks), defendant's treating psychologist at Napa State Hospital from April 2017 until May 15, 2018, testified defendant suffers from schizoaffective disorder, narcissistic personality disorder, alcohol and cannabis disorders, and antisocial personality traits. Dr. Marchbanks observed defendant manifesting schizoaffective disorder by "becoming paranoid," "being really intrusive, very verbally aggressive," and presenting with "pressured speech." He had also shown a decreased need for sleep. When defendant is not medicated, according to this psychologist, his behavior and thinking are very disorganized. Dr. Marchbanks has seen defendant off his medication, and in her opinion, he "definitely benefits from being on medication" because when he is off his medication he is "much more angrier [*sic*], much more aggressive verbally," is "not really redirectable with staff," does not sleep, and "tends to get into a lot of verbal conflicts on the units, a lot more than he would if he was medicated." Defendant had repeatedly questioned his medication dosage, complaining he was taking too much. If defendant stopped taking his medication, in Dr. Marchbanks's opinion, "his behavior would quickly change." He would become more verbally aggressive, intrusive, irritable, and his mood would be more unstable due to his inability to sleep. As a result, he would pose a substantial danger of physical harm to others.

In discussing defendant's need for medication, Dr. Marchbanks related, based on her review of documentation, that on June 1, 2018, defendant approached the nurses' station with "tense facial musculature, glaring eyes and pressured speech," stating, "I'm so tired and agitated with staff, bullshit[t]ing me on this thickener, day and night, out, even with my water all day, plus things around me making me so mad, give me my PRN for agitation right now." Because he was restless and angry, the PRN medication, olanzapine, an antipsychotic, was given to him. After taking the medication, defendant told the staff he had slept after he took the PRN and felt better. He appeared calm and spoke in a lower tone. In another incident on May 10, defendant had a physical altercation with a peer; he had clenched fists. When he was unable to calm down in a side room, he was administered olanzapine, and later reported he was feeling better.

Dr. Marchbanks was primarily concerned with the ill effects of reducing defendant's medication. Though defendant has an adequate understanding of his mental illness, when he has asked for and received a reduction in his medication, he has become either "delusional or hearing voices or paranoid," behaviors which have "gotten [him] in trouble." The doctor explained if someone is out in the community and no PRN's are available, the individual might have difficulty regulating his or her mood, anger, or aggression. Likewise, if defendant were released to an "unsupervised environment," in the doctor's expert opinion, he would not take his medication because, since she had worked with him, he complained about being on too many medications and consequently, "doesn't have the insight to link" that when he does not take his medication "his violence—his risk for violence, for potential violence increases." This is because he is not stable, he is "much more irritable," and "not very directable." In forming her opinion, Dr. Marchbanks took into consideration a December 2017 incident in which defendant "cheeked" a medication pill and hid it in his room because he wanted to "double up." The doctor was troubled by this incident because if a patient is not following the guideline, he or she could overdose which could be deadly or cause side effects, and "all sorts of complications." Dr. Marchbanks also considered instances in which defendant refused to take his antipsychotic medication. In her opinion, if

defendant were in an unsupervised setting out in the community, there would be no one to "encourage him" to take his medications, and "[h]e could just stop taking them and would rapidly decompensate." And if defendant stopped taking his medications, the doctor believed he would likely do something violent.

Dr. Marchbanks concluded defendant poses a substantial danger of physical harm to others and has serious difficulty controlling his dangerous behavior. In reaching her conclusion, the doctor relied upon defendant's prior assault convictions, the interdisciplinary notes in defendant's file at Napa State Hospital, and the nursing notes, in addition to her daily observations of defendant and the interviews she had with him. Dr. Marchbanks explained the interdisciplinary notes reflect a "clear pattern of just verbal aggression and argumentativeness with staff." Defendant was "very demanding and entitled" and would often become upset if his needs were not immediately met.

That defendant has had no recently recorded incidents at the hospital of physically attacking anyone did not change Dr. Marchbanks's opinion because he is in a very artificial, structured, and supportive environment where staff is available 24 hours a day, seven days a week. Consequently, staff is there to intervene when defendant becomes verbally aggressive, and is able to stop his aggression before it ramps up to a physical altercation. Placing defendant in a "less supervised setting," according to the doctor, would "definitely increase" the risk of physical aggression because nobody would be there to intervene or "help deescalate a situation of that sort."

Dr. Marchbanks's opinion was bolstered by defendant's prior performance when he was released from the state hospital to enter the conditional release program (CONREP). CONREP places patients released from the hospital in a board-and-care home where they are supervised "somewhat." Defendant was first released to CONREP in 1994. He was in the program for about eight days before he decompensated, becoming verbally and physically aggressive. Later that year, defendant was released a second time and was living outside the hospital for over a year until he was placed on CONREP probation in April 1996 for not following the rules, defrauding the ATM or his bank of $140, and not being "redirectable." After defendant was placed on probation, he

absconded because he feared being sent back to the hospital. He was returned to Napa State Hospital and was released again in 2002. Defendant was out for approximately two weeks, but his release was revoked because he had become "paranoid and delusional and aggressive and was not— . . . receiving help—or he wouldn't accept the help that was being offered."

Dr. Kimberly Smith

The second psychologist to testify was Kimberly Smith. She has a contract with CONREP to go into the hospitals every six months to conduct evaluations and monitor patient progress to determine whether a patient qualifies for CONREP. Since December 2015, Dr. Smith had seen defendant every six months; however, on two occasions he declined to meet with her. On three occasions, the doctor spoke with him. Taking into account her interviews with defendant and her review of his medical records, Dr. Smith opined he suffers from schizoaffective disorder. Based on her discussions with defendant, the doctor did not believe defendant had learned from his prior experiences in CONREP because he did not appreciate the problems he had had in CONREP and because there were inconsistencies in his portrayal of what had happened while he was in the program. In speaking with defendant about "what his precursors were or what triggered him," the doctor explained defendant struggled to rationally speak about his precursors. In one interview, defendant spoke about "people in control, particularly females exerting their power over him," but in the most recent interview, he could not say anything logical. He mentioned water and ice, and spoke of other things that did not make sense. Following her interviews with defendant, Dr. Smith believed defendant could only "[m]inimally" describe what triggers him.

Dr. Smith did not believe defendant was an appropriate candidate for CONREP because he lacked insight into his mental illness. While defendant acknowledged to her that he has a mental disorder, he could not recognize the symptoms. As an example, before Dr. Smith saw defendant in November 2017, one or two months earlier he had decompensated and had some manic symptoms, including paranoia. Yet, defendant told her that he had been stable for years with no problems. And when Dr. Smith saw

defendant again in June 2018, he was significantly more disorganized in his thought process. Because defendant tended to "ramble and talk non-stop about various different topics" having nothing to do with the questions posed, Dr. Smith had a difficult time getting defendant to answer most of her questions. During this interview, the doctor was concerned defendant was not able to talk clearly about his mental illness because if he is not able to verbalize or recognize his symptoms in the hospital, he will not be able to recognize them or appropriately manage them in the community as CONREP provides very little supervision. Dr. Smith also noted defendant relies "heavily on staff assistance to manage his symptoms and behavior in the hospital," and he cannot articulate any reasonable plan to address how he would manage his mental illness, aggressive behavior, or substance abuse in the community.

If released into the community, in Dr. Smith's opinion, defendant would "psychiatrically decompensate even further" and would not be able to manage his aggressive behavior. The doctor elaborated that CONREP patients are not generally supervised at the same degree as state hospital patients since they are living in room-and-board or board-and-care housing where staff is not there "24/7 to provide them with medications." Additionally, CONREP needs individuals who will independently take their medications. In an unsupervised environment, Dr. Smith did not believe defendant would take his medication given his recent documentation, his record of consistently asking for a decrease in his medication, his history of failing to take his medication appropriately in the community, and his disorganized thoughts which would make it challenging for him to manage his own medication. Asked whether, due to his mental disorder, defendant poses a substantial danger of physical harm to others and has serious difficulty controlling his dangerous behavior, Dr. Smith responded that because defendant has struggles controlling his aggressive behavior in the hospital with the assistance of staff, and he requires a lot of staff intervention when he is having verbal arguments with other patients, she did not think he could manage his own behavior. Lastly, the doctor stated her opinion would not change even though defendant had not been involved in any physical assaults over the last few years because he has continued to

get into "heated verbal arguments with other patients and staff," which is consistent with a long-standing history of requiring staff to intervene to "deescalate him, and apparently that can be quite difficult for staff."

Nurse David Lundberg

The first of the two nurses to testify was David Lundberg from Napa State Hospital. In his personal dealings with defendant, Lundberg had to redirect him "maybe twice a week." Lundberg explained redirection takes place when he sees two people engaging in a verbal or physical altercation at which point, he "redirect[s] them to a different type of conversation or to a quiet area to talk about their issues instead of it furthe[r] escalating." He had to redirect defendant when he came to the nurses' station at an inappropriate time, made some unreasonable request, or during interactions with peers. When defendant has come to the nurses' station at an inappropriate time and staff tells him he needs to come back later, he sometimes becomes angry and demanding. Lundberg also testified defendant had not been physically violent with him, nor had he seen him become physically violent with other staff or patients.

Nurse Diana Heying

Diana Heying, a nurse at Napa State Hospital, described defendant as "[d]emanding and controlling." She described two 2018 incidents in which defendant invaded someone else's space: first, when he entered a treatment room where Heying was treating a patient, and second, when he was found in a peer's room with the door closed, claiming he was looking for stamps. Because defendant engaged in improper "unit protocol," on both occasions, defendant was redirected, and Heying documented the incidents since defendant was invading another patient's space and privacy. Earlier, in 2017, defendant also invaded a patient's personal space. While a patient was receiving medication at the medication window, defendant stepped into the red outlined space, an area to provide some personal space for other patients. After staff asked him to step behind the red line, he waved his hands like he was "shooing something away" and professed to be "getting rid of evil spirits."

Heying further testified defendant will "oftentimes" raise his voice to make a demand or when he does not get his way. In February 2018, for example, defendant pounded on the nurses' station window, demanding in a loud voice, "[B]itch, give me my snack." He accused the individual on the other side of the nurses' station window of being a "racist." Defendant also said, "[T]hat's why she can't testify against me in court, because she's racist." Once defendant was given his snack, he was redirected and walked away again stating in a loud voice, "[S]he's racist." Lastly, Heying described an occasion when defendant spoke to her in a threatening manner and blocked a doorway preventing her from exiting a treatment room. She asked defendant to step away from the door and come with her to the nurses' station. He did not want to go to the nurses' station but eventually backed away from the door enough that Heying could get out of the room.[3]

Social Worker Thomas Furusho

Social Worker Thomas Furusho is an employee of Napa State Hospital. He had been seeing defendant since around April 2017. Though defendant was not on Furusho's caseload, defendant attended groups Furusho was facilitating, including community reentry, enhancing motivation, relapse prevention, and anger management. Defendant's participation in groups was, according to Furusho, "a mixed bag." Sometimes defendant was engaged and fully participated, but there were instances when Furusho had difficulty with him. Furusho testified that one day in September 2017, defendant was experiencing "a bit of a tough day." On a "couple separate occasions," while Furusho was walking down the unit hallways, defendant approached him to have his needs addressed while Furusho was involved with other duties. When Furusho told defendant that he would speak with him later, defendant stepped in front of him—once at the nurses' station door and once at the treatment program door. Though defendant did not physically touch

[3] Nurse Heying testified about several other incidents. Defendant asked her to remove notations from his medical file that he had refused treatment. On a different occasion, defendant took three puffs from an inhaler. After Heying told him he only should take two, defendant became angry and walked out of the room.

Furusho, he could not maneuver around defendant to get near the doors. During these encounters, defendant's demeanor was "[v]erbally aggressive, irritable"; he raised his volume and tone. Furusho felt it was important to document these incidents on defendant's chart because "this was potentially dangerous behavior." Furusho felt vulnerable as he could have been assaulted by defendant or someone else. Again, in September 2017, while Furusho was walking out of the nurses' station, defendant followed, speaking to him "very closely, verbally aggressive, elevated volume and tone." After Furusho asked defendant to give him more space, defendant continued to follow Furusho without giving him "much more physical space but within a foot and a half." Because there was not enough physical space for Furusho to escape if he was attacked, he felt this was a dangerous situation. Defendant did not assault him but even if it "wasn't him, just someone else," Furusho believed he needed more space around him to react.

On at least two other occasions in March 2018, while Furusho was conducting group treatment, defendant exhibited troubling behavior. Defendant would either not allow other participants, including Furusho, to speak or would begin talking at the same time as other participants. When Furusho attempted to redirect defendant's behavior or asked him to wait, defendant became angry, elevated his voice, and left the room angrily when Furusho asked him to leave. Defendant repeated this conduct during community reentry group. In this group, Furusho allows patients to use the telephone to call family, friends, or outside resources. On this occasion, while another patient was on the phone, defendant began talking over this person. Since defendant had already used the phone that day, Furusho asked him to wait, but defendant continued to speak "over them" and Furusho. Defendant became angry when Furusho asked him to leave the room.

B. Defense Case

Defendant was the sole witness for the defense. No expert witnesses or Napa State Hospital staff testified on defendant's behalf.

Defendant testified he has been diagnosed with schizoaffective disorder bipolar, personality disorder, antisocial narcissistic personality disorder. His major symptoms, leading to decompensation, are "hearing voices or seeing things," "[b]ecoming

delusional, racing thoughts, [and] aggravated emotions." Defendant indicated his triggers are "violence, verbal abuse, anniversaries." Violence is triggered when "somebody wants to commit a verbal or physical attack" against him. And defendant's "anniversaries" trigger occurs every September because the last time he saw his mother was during that month. According to defendant, his "safe strategies for coping with [his] mental illness" include writing in his journal daily, doing pushups when he wakes up in the morning, engaging in artwork, doing tai chi, and seeking assistance from staff or making a complaint. Early warning signs of decompensation include a loss of hygiene and increased paranoia.

Defendant addressed his prior assaultive conduct. As to the 1989 incident in Fresno for which he was convicted of assault with a deadly weapon, defendant stated he was drinking, taking his medication, and smoking marijuana daily. He got into an altercation and, with a knife, stabbed the other person twice. Defendant claimed the other person "was after me, protect myself, so that was that." At the time of this assault, defendant admitted he was paranoid. As to the 2005 incident at Napa State Hospital where defendant assaulted another patient, he testified he was experiencing symptoms of paranoia due to his mental illness. Defendant claimed he became paranoid because his doctor in the unit changed his medication. Because that medication was causing him "mental problems and serious physical problems," he went to his doctor who changed his medication.

Defendant has been taking medications for his mental illness since 1982. Although defendant has asked for PRN's in the past, he testified he has not asked for any recently. He asks for PRN's when he is angry, loses his composure, and wants to verbally lash out. Defendant agrees he suffers from schizoaffective disorder and testified he will take his medication until the end of his life, though he would prefer a lower dose of his medications due to falling asleep in his group therapy and tremors, side-effects of the medications. Even though Dr. Saini observed defendant decompensate fairly quickly after his dosage of olanzapine was reduced, defendant did not recognize any connection between the decrease in his dosage and an increase in the signs and symptoms of his

mental illness and in his requests for PRN's. Defendant was "happy" to be "away from Dr. Saini's attention span because he's not a good doctor."

If released into the community, defendant's plan would be to either go into a six-month drug and alcohol treatment program or move in with his sister. He would live off his disability check or find a part-time job. Defendant testified he would attend Alcoholics Anonymous and Narcotics Anonymous fellowship meetings where he would "look on the board" for jobs. Defendant maintained he would continue to take his medication without supervision to avoid decompensating. Contrary to Dr. Smith's opinion that defendant is not a good candidate for CONREP, defendant claimed the doctor was "not really a fair person," and he would "take" CONREP. Defendant admitted he had been unsuccessfully released to CONREP on three previous occasions, the last time in 2002. He attributed his failure on CONREP to a doctor improperly prescribing his medication. During one of his releases, he stopped taking his medication when he went AWOL from CONREP. Defendant insisted that after he left, he took his medications with him but all he could recall was he "blacked out," and the police arrested him. He claimed he always took his medications when he was in CONREP.

II. DISCUSSION

Under section 1026.5, subdivision (a)(1), a person committed to a state hospital after being found not guilty by reason of insanity may be kept in custody no longer than the maximum term of commitment. However, if that person committed a felony and represents a substantial danger of physical harm to others by reason of a mental disease, defect, or disorder, then the prosecuting attorney may file for a two-year commitment extension. (§ 1026.5, subd. (b)(1), (2) & (8).)

The prosecution must prove beyond a reasonable doubt the defendant suffers from a mental disease, defect, or disorder, and as a result of his mental disease, defect, or disorder, the defendant poses a substantial danger of physical harm to others and has serious difficulty in controlling his or her behavior. (*People v Bowers* (2006) 145 Cal.App.4th 870, 877–878.) "[W]hether any alleged mental disease, defect, or disorder causes a person to represent a substantial danger of physical harm to others is

'not a question of law, but rather one for the trier of fact to be resolved with the assistance of expert testimony.' " (*People v. Williams* (2015) 242 Cal.App.4th 861, 872 (*Williams*).)

"We review an order to extend commitment under section 1026.5 by applying the substantial evidence test, examining the entire record in the light most favorable to the order to determine whether a rational trier of fact could have found the requirements of the statute satisfied beyond a reasonable doubt." (*Williams*, *supra*, 242 Cal.App.4th at p. 872.) Substantial evidence is evidence that is " 'reasonable in nature, credible, and of solid value.' " (*People v. Johnson* (1980) 26 Cal.3d 557, 576.) Expert testimony is considered substantial evidence if it is supported by " 'relevant probative' " facts, rather than " 'guesswork, surmise or conjecture.' " (*People v. Zapisek* (2007) 147 Cal.App.4th 1151, 1167–1168.) "A single psychiatric opinion that a person is dangerous because of a mental disorder constitutes substantial evidence to justify the extension of his commitment." (*Williams*, at p. 872.) We do not, however, reweigh the evidence or reevaluate the credibility of witnesses, and "[i]f the circumstances reasonably justify the trier of fact's findings, reversal of the judgment is not warranted simply because the circumstances might also reasonably be reconciled with a contrary finding." (*People v. Lindberg* (2008) 45 Cal.4th 1, 27.)

There Was Substantial Evidence from Which a Reasonable Jury Could Find Defendant Had Serious Difficulty Controlling His Behavior

Defendant's sole contention on appeal is there was insufficient evidence defendant had serious difficulty controlling his dangerous behavior. He argues reversal in the present case is required under *People v. Galindo* (2006) 142 Cal.App.4th 531 (*Galindo*).

In *Galindo*, the appellate court reversed the trial court's entry of judgment pursuant to section 1026.5 because it prejudicially failed to consider whether the defendant had serious difficulty in controlling his behavior. Defendant contends reversal here is required under *Galindo* since much of the evidence relied on by the prosecution to prove defendant's inability to control his dangerous behavior—that he would frequently become angry with staff if they did not comply with his requests, that he was not adept at

recognizing his decompensation, or that he frequently requested a decrease in medication without acknowledging this may cause an increase in his symptoms—"mirrors that in *Galindo*."

The trial court in *Galindo* held a bench trial and extended the commitment of a defendant who was diagnosed with bipolar disorder without making an express or implied finding the defendant had serious difficulty controlling his behavior. The Court of Appeal held the error was prejudicial because, although there was "abundant evidence that defendant's behavior was dangerous and that he did not, in fact, control it[,] . . . the fact he *did not* control his behavior does not prove he *was unable to do so*, thus making him 'dangerous beyond [his] control.' " (*Galindo, supra*, 142 Cal.App.4th at p. 539; see *In re Howard N.* (2005) 35 Cal.4th 117, 138 ["There was, however, no evidence that defendant's mental abnormality caused him serious difficulty controlling his sexually deviant behavior."].) Remand was necessary in *Galindo* because "the evidence was not such that *any* rational jury would have found that" the defendant had serious difficulty controlling his dangerous behavior due to his mental disorder. (*Id.* at p. 539.)

Here, however, the question is not whether a reasonable trier of fact could have found in defendant's favor on the control issue, but whether substantial evidence supports the jury's express finding that defendant has serious difficulty controlling his dangerous behavior as a result of his mental disorder. As detailed above, several experts, two psychiatrists and two psychologists, opined that due to defendant's mental illness of schizoaffective disorder, he not only poses a substantial danger of physical harm to others, but he has serious difficulty controlling his behavior. Substantial evidence was presented at trial supporting the experts' conclusion defendant has serious difficulty controlling his behavior. The doctors explained defendant is easily angered, verbally aggressive, irritable, moody, and suspicious of his peers and treatment team. Although defendant is medicated and in a supervised, secured environment, he has engaged in threatening and potentially dangerous behavior. Dr. Saini, for example, indicated there were approximately "20, 25 incidences" in which defendant was acting out, becoming angry, argumentative, demanding, and threatening. Dr. Marchbanks described an

incident in which defendant approached the nurses' station in an agitated state with "tense facial musculature, glaring eyes and pressured speech," stating he was "so tired and agitated with staff, bullshit[t]ing me on this thickener, day and night, out, even with my water all day, plus things around me making me so mad, give me my PRN for agitation right now." In another incident, in February 2018, involving the nurses' station, Nurse Diana Heying reported defendant pounded on the nurses' station window demanding in a loud voice, "bitch, give me my snack," accusing the individual inside the station of being "racist."

In several troubling situations involving Nurse Heying and Social Worker Furusho, defendant engaged in threatening behavior by blocking doorways and hallways making it very difficult to maneuver around him. He spoke to Heying in a threatening manner, and was verbally aggressive toward Furusho, speaking in an elevated volume and tone. Because there was not enough space for Furusho to escape if he were attacked by defendant or someone else, he felt this was a dangerous situation. Moreover, because defendant lacks insight into his mental illness, he has been unable to properly address it, and he has not been willing to accept feedback from his treatment team to help himself gain the necessary insight.

Importantly, he has a history of repeatedly asking for a reduction in his medication, having his medication reduced, and then decompensating, resulting in increasing symptoms of agitation, anxiety, irritability, delusions or hearing voices, and paranoia. Dr. Marchbanks, in fact, pointedly testified defendant does not have the insight to understand that when he does not take his medication, his risk for potential violence increases. Finally, defendant is not a good candidate for CONREP because, according to Dr. Smith, he has not learned from his prior failed experiences in CONREP. While defendant acknowledged to her that he has a mental disorder, he could not recognize his symptoms. He also relies heavily on staff to manage his symptoms and behavior in the hospital, support and supervision not available in CONREP. If defendant were released to an unsupervised environment, Drs. Marchbanks and Smith specifically expressed concern, he would stop taking his medications, and as a result, he would be unable to

manage his aggressive behavior, would rapidly decompensate, and would likely do something violent.

To the extent defendant argues he has not engaged in any assaultive behavior since 2005, three experts, Drs. Saini, Marchbanks, and Smith, indicated their opinions would not change because defendant is housed in one of the most highly structured, supervised, and supportive units at Napa State Hospital where staff is available 24 hours, seven days a week and can intervene when defendant becomes verbally aggressive to stop his aggression before it escalates into a physical altercation. The jury heard evidence defendant had not engaged in physically assaultive behavior since 2005, and still concluded based on the totality of the evidence, defendant has serious difficulty in controlling his behavior. The jury also had the opportunity to observe and evaluate defendant, and judging from its verdict, the jury did not credit defendant's testimony. And as previously noted, on appeal, we do not reweigh the evidence and reevaluate the credibility of witnesses. Further, while relevant, defendant's history of alleged nonviolence at the hospital is not dispositive, nor did it preclude the jury from finding defendant poses a substantial danger to others and has serious difficulty in controlling his dangerous behavior. (See *People v. Zapisek*, *supra*, 147 Cal.4th at pp. 1167–1168 [substantial evidence supported finding that defendant represented a substantial danger to others, even though he did not engage in acts of physical violence during hospitalization].)

In sum, we see no reason to question the jury's determination defendant has serious difficulty in controlling his behavior. As explained in *People v. Kendrid* (2012) 205 Cal.App.4th 1360, 1370, "The People are not required to prove the defendant ' "is *completely* unable to control his behavior." ' [Citation.] Instead, the defendant's 'impairment need only be serious, not absolute.' "

III. DISPOSITION

The judgment is affirmed.

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Margulies, J.

We concur:

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Humes, P. J.

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Sanchez, J.

A154893
People v. Jeffrey G.